Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX Health DBA Injury 1 - Dallas

Respondent Name
Memic Indemnity Co

MFDR Tracking Number
M4-14-3140-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…it is our position that MEMIC has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered…"

Amount in Dispute: $1,649.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This matter should be dismissed, as the medical review division does not have jurisdiction to address the relatedness issue that is the basis for this dispute."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18 through December 18, 2013	Professional Medical Services	$1,649.22	$1,152.48

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §124.2 sets out carrier reporting and notification requirements.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §134.210 defines medical documentation.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medial Fee Guidelines
   - W1 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Was the Division requirements met, when Carrier sent notification to the health care provider?

2. Did the requestor raise a new issue?
3. Were the codes submitted on the medical bill supported by documentation?
4. What is the rule applicable to reimbursement guidelines?
5. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §124.2 "(f) states in pertinent part, "Notification to the claimant as required by subsections (d) and (e) of this section requires the carrier to use plain language notices with language and content prescribed by the Commission. These notices shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim. A generic statement that simply states the carrier's position with phrases such as "employee returned to work," "adjusted for light duty," "liability is in question," "compensability in dispute," "under investigation," or other similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this section." Review of the submitted medical documentation finds;
   - Recommended Allowance shown on reprint of "Explanation of Benefits Alternative Form DWC 62" for dates of Service, November 18, 2013, November 26, 2013, December 2, 2013, December 5, 2013, December 13, 2013, December 17, 2013, December 18, 2013. No denial or plain language notice statement was contained in these notifications to the health care provider.
2. The respondent in their position statement state, "…The ongoing dispute appears to be relatedness of the treatment to the compensable hand contusion injury." Per 28 Texas Administrative Code §133.307(d)(F), "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section." Review of the submitted documentation (Explanation of Benefits Alternative Code DWC 62) found no denials for compensable injuries were made by the Carrier. Therefore, the respondent's position statement will not be considered in this review. The services in dispute will be reviewed per applicable rules and fee guidelines.
3. The requestor submitted code 99082, "Unusual travel (eg, transportation and escort of patient)." No documentation was found to support this claim as submitted. 28 Texas Administrative Code §133.210(a) states, "Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results and (b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents." Review of the submitted documentation finds no records to support this service as submitted therefore, this code will not be considered for payment as the requestor did not meet requirements of applicable rule.
4. Per 28 Texas Administrative Code §134.203 (c) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)." The maximum allowable reimbursement will be calculated as follows;
   - Procedure code 97530, service date November 18, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.44396. The practice expense (PE) RVU of 0.58 multiplied by the PE GPCI of 1.017 is 0.58986. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 1.04216 is multiplied by the Division conversion factor of $55.30 for a MAR of $57.63. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $57.63. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $55.00.
   - Procedure code 97110, service date November 18, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is

0.45405. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.017 is 0.48816. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.95055 is multiplied by the Division conversion factor of $55.30 for a MAR of $52.57. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 3 units is $117.21.

- Procedure code 97110, service date November 26, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.017 is 0.48816. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.95055 is multiplied by the Division conversion factor of $55.30 for a MAR of $52.57. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 3 units is $117.21.
- Procedure code 97530, service date November 26, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.44396. The practice expense (PE) RVU of 0.58 multiplied by the PE GPCI of 1.017 is 0.58986. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 1.04216 is multiplied by the Division conversion factor of $55.30 for a MAR of $57.63. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $57.63. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $55.00.
- Procedure code 97110, service date December 2, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.017 is 0.48816. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.95055 is multiplied by the Division conversion factor of $55.30 for a MAR of $52.57. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 3 units is $117.21.
- Procedure code 97530, service date December 2, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.44396. The practice expense (PE) RVU of 0.58 multiplied by the PE GPCI of 1.017 is 0.58986. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 1.04216 is multiplied by the Division conversion factor of $55.30 for a MAR of $57.63. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $57.63. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $55.00.
- Procedure code 97110, service date December 5, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.017 is 0.48816. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.95055 is multiplied by the Division conversion factor of $55.30 for a MAR of $52.57. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the

procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 3 units is $117.21.

- Procedure code 97530, service date December 5, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.44396. The practice expense (PE) RVU of 0.58 multiplied by the PE GPCI of 1.017 is 0.58986. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 1.04216 is multiplied by the Division conversion factor of $55.30 for a MAR of $57.63. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $57.63. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $55.00.
- Procedure code 97110, service date December 13, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.017 is 0.48816. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.95055 is multiplied by the Division conversion factor of $55.30 for a MAR of $52.57. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 3 units is $117.21.
- Procedure code 97530, service date December 13, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.44396. The practice expense (PE) RVU of 0.58 multiplied by the PE GPCI of 1.017 is 0.58986. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 1.04216 is multiplied by the Division conversion factor of $55.30 for a MAR of $57.63. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $57.63. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $55.00.
- Procedure code 97110, service date December 17, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.017 is 0.48816. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.95055 is multiplied by the Division conversion factor of $55.30 for a MAR of $52.57. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 3 units is $117.21.
- Procedure code 97530, service date December 17, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.44396. The practice expense (PE) RVU of 0.58 multiplied by the PE GPCI of 1.017 is 0.58986. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 1.04216 is multiplied by the Division conversion factor of $55.30 for a MAR of $57.63. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $57.63. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $55.00.

- Procedure code 99213, service date December 18, 2013, the Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.97873. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 1.017 is 1.1187. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.834 is 0.05838. The sum of 2.15581 is multiplied by the Division conversion factor of $55.30 for a MAR of $119.22.

5. The total allowable reimbursement for the services in dispute is $1,152.48. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $1,152.48. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,152.48.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,152.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April 14, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.